Re-Engineering Residential Treatment:

Challenges and Opportunities for Purchasers and Providers

Background Paper for the

Children in Managed Care Initiative

Center for Health Care Strategies

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I. Understanding Residential Treatment

Group Residential Care is usually defined as a service that provides 24-hour care in a residential type facility designed as a therapeutic environment. Within that setting, a child/adolescent is provided integrated treatment services, educational services and group living on the basis of a treatment plan. It is assumed that children are placed in these centers because they can no longer be cared for in their own homes or substitute families i.e., foster home, relative or kinship placement. (CWLA, 1982)

The two dominant forms of Group Residential Care are

- Residential Treatment Centers
- Community-based group homes

The size of such facilities is typically defined to include as few as eight children to as many as several hundred children depending on state licensing definitions and rules. The usual services children receive are counseling, education, recreation, health, nutrition, daily living skills, reunification and independent living training as appropriate. (CWLA, 1991)

Group Residential Care services are provided and/or funded under the auspices of:

- Child mental health
- Child welfare
- Juvenile justice
- Special education
- Public/private sources
- Medicaid/insurance
- Non-profit agencies
- For Profit agencies

Children in Residential Treatment Centers have been, or tend to be, clients of all major children's systems. There is not one major sector of care, in which these children are referred into residential treatment. (Whittaker, 2000)

An accurate picture of the number of youth in group residential care is difficult to ascertain-particularly one based on more recent trends. According to the American Public Welfare Association report in 1996, there were 530,496 children in out-of-home care. While the majority of these children were in family foster care, it is estimated that approximately 25% or over 132,000 children/adolescents were in group residential care. However, these figures may not include both mental health and juvenile justice youth in certain placements, particularly those in residential treatment type beds in public and private hospitals.

II. Background and General Trends

The evolution in this country of a "systems of care" philosophy and approaches to better coordinate the delivery of services to children and adolescents with comprehensive emotional, behavioral and mental health needs has had a profound impact on the role of group residential care. While that impact varies from community to community, in many states, the utilization of these services has declined over recent years.

In Illinois, for example, the number of children in residential care has dropped from more than 7000 five years ago to 1600 in 2002. In Indiana, the Department of Family and Social Services Administration has set a goal to reduce the number of children in residential care by 500 in the next two years. A decade ago in Arizona, there were 400 residential treatment beds in the State and that has dropped nearly in half. In Kansas, child welfare contracts set targets for contractors that 85% of children in out-of-home group residential care be served in community foster homes. Most counties in Colorado are now paying for short-term residential care (3-6 months) rather than traditional long-term care. In Wayne County Michigan (Detroit) there has been a 46% reduction in residential treatment for adjudicated delinquent youth. Average daily occupancy has declined in Wisconsin residential centers by 25%. In Milwaukee County, Wisconsin, the average daily census of youth in residential

treatment centers dropped from 375 youth in 1995 to 50 youth in 2002. (Information courtesy of Wisconsin Association of Family and Children's Agencies).

While there are other states and communities that have not seen such dramatic changes in residential usage, declining state and federal revenues will probably cause this trend to continue as communities look for less expensive treatment alternatives for children and adolescents. In addition, there is a growing body of research on the efficacy of home and community-based alternatives to residential treatment, and states are increasingly interested in purchasing evidence-based practices.

Current trends that are emerging in Group Residential Care in this country include:

- Declining Utilization – the average daily occupancy for children in these centers has been declining over recent years (Wisconsin Association of Family and Children's Agencies).
- Higher Need Children Being Placed – Residential Centers are often taking the place of psychiatric hospitals in treating youth with more serious mental health, emotional and behavioral needs.
- Lengths of Stay are Shorter – Children and adolescents are staying for much shorter periods of time in these centers.
- Fewer Available Beds – As utilization declines, it can be expected that there will be fewer available residential beds.
- A Clear Shift Toward Community Based Care – The movement toward treating children in the community and the evolution of "systems of care," treating children in the "least restrictive alternative," and "wraparound approaches" has become stronger.
- Increased Focus on Mental Health – More children are being placed with mental health needs and fewer with only dependency needs.
- Declining Funding Sources – Declining state and federal reserves have made purchasers more reluctant to place children in very costly residential care, particularly with little research to support overall long-term effectiveness.
- Managed Care – More children are enrolled in managed care, which is reluctant to pay for costly residential treatment.

- Workforce Issues – The loss of funding and higher costs to maintain adequate staffing levels, i.e., salaries, health insurance, liability, etc., take their toll on the ability of these centers to attract and maintain the highest quality of staff. More staff with residential care experience are finding better job opportunities in community-based settings.

III. General Criticisms of Residential Treatment

The decline in residential care usage in recent years can be linked to some general, but often valid criticisms of this type of care. These include:

- Distrust in general about institutionalization that creates separation and breaks bonds between children and their families.
- Concerns about stigma attached to children placed in residential centers and among the families who have felt compelled or required to place them there.
- Absence of hard evidence that residential treatment is effective, particularly on a long-term basis.
- All too frequent reports and stories in the news media of physical, sexual and psychological abuse of residents of these residential facilities.
- No agreed upon treatment protocols and too few individualized service approaches. Treatment tends to be very generic and not very time focused.
- Residential care is too expensive versus community-based alternatives, and is getting more expensive yearly at a time when purchasers have fewer dollars to buy services.

Some of these concerns were expressed several years ago in a report from the U.S. General Accounting Office. "Not enough is known about residential care programs to provide a clear picture of which kinds of treatment approaches work best or about the effectiveness of the treatment over the long term….. No consensus exists on which youths are best served in residential care…or how it should be combined with community-based care to serve high-risk youth." (GAO, 1994)

In his 1999 Report to the President on the State of Mental Health in this country, US Surgeon General David Satcher stated these thoughts on residential care, "In the past, admission to

Residential Treatment Centers has been justified on the basis of community protection, child protection and benefits of residential treatment per se. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings. (Satcher, 1999)

IV. Toward Re-Engineering Residential Treatment Services

Given the criticisms of residential treatment and orientation of Purchasers who are looking for more evidenced-based, cost effective approaches to treating the most troubled youth, there is an opportunity to re-conceptualize the role of group residential care. That role needs to be conceptualized within a framework of a system of care values and philosophy. These include: that care is individualized and strength-based; that children's mental health, emotional and behavioral needs must be based in the context of their families strengths, needs and resources; that the most effective supports and services are those that are delivered in the community; that services must be culturally competent wherever they are provided; that the best responses to meeting the comprehensive needs of children and families can only occur if all parties, including residential centers are truly collaborative in the design, development and implementation of the core plan; that financing care must be made as flexible as possible and that the attainment of positive, measurable outcomes for children must be at the end of our efforts.

V. The Role of Group Care/Residential Treatment within a Model System of Care-Wraparound Milwaukee

Wraparound Milwaukee is a national model in providing services to children with serious emotional and mental health needs. First funded in 1995 under a Comprehensive Children's Mental Health Services Grant from the Center for Mental Health Services (CMHS), Wraparound Milwaukee's development and growth significantly impacted residential treatment providers. By 1995, Milwaukee County had a significant and growing number of both child welfare and delinquent youth in residential treatment centers. There were nearly 400 youth on average daily placed in these centers at a cost of nearly $18.5 million per year.

The increasing rate of placement was creating year-end deficits for child welfare and juvenile justice. The outcomes for youth returning home from these centers was marked by high rates of recidivism and return to the centers or more restrictive correctional placement. Lengths of stay, on average exceeded 14 months in the residential center.

While Medicaid in Wisconsin has never paid for residential treatment placements directly under the State Plan, Medicaid was seeing an increase in inpatient psychiatric hospitalization for children who were initially placed in inpatient facilities before going into residential centers, those who needed frequent stabilization in the hospital while in placement in the residential center and for children with failed residential placements who had no where else to go.

The Policy makers in Milwaukee County and the State were looking for better alternatives to residential treatment and psychiatric inpatient care. Wraparound Milwaukee was primarily developed as a system of care to provide community-based services that would reduce the need for residential treatment services or when institutional care was needed to better manage how those services were provided.

Working within a wraparound philosophy that emphasized strength-based, family focused, and highly individualized care, Wraparound Milwaukee has been able to more effectively meet the needs of these children and families in the community. Through using service components including care coordinators, comprehensive Provider Networks, Mobile Crisis Teams, Family Advocacy and informal community supports, services are now able to be "wrapped" around the child and family. Children who were never thought to be good candidates for community-based care are now being successfully cared for in their families.

Operationally, Wraparound Milwaukee was set up as a type of Public Health Maintenance Organization. The funding child welfare and juvenile justice previously spent annually entirely on residential treatment placements now comes to Wraparound Milwaukee through a case rate formula and is pooled with Medicaid funds that were previously paid for psychiatric hospitalization and mental health/substance abuse services for these youth. Medicaid

funding comes through capitation payments to Wraparound Milwaukee as the Managed Care Organization (MCO). A very flexible funding pool is created. Wraparound Milwaukee now arranges, pays for, and manages all mental health, substance abuse, social and other support services. Residential Treatment, when utilized, is now paid for all Milwaukee County youth on a fee-for-service basis by Wraparound Milwaukee.

Since moving to this model in 1997, Wraparound Milwaukee has been able to reduce the average daily number of youth in residential placement from 375 to 50 youth, the average residential stay has decreased from 14 months to 90 days and the average cost per child decreased from $7,000 monthly for pure residential care to $4,300 for all services for a child enrolled in Wraparound Milwaukee. The overall expenditures by child welfare and juvenile justice in 2002 were $18.1 million to serve an average enrollment of 540 youth versus $18.5 million in 1995 to care for about 375 youth. Medicaid, who funds Wraparound at 95% of the 1995 level, has seen psychiatric inpatient care decrease from over 5000 days to less than 200 days per year.

While initially threatening to residential treatment centers, Wraparound Milwaukee has been successful in partnering with residential care providers to explore new ways of incorporating residential providers in the service continuum. Based on seven years of experience, Wraparound Milwaukee offers this perspective on some "best practice" approaches for Residential Treatment Centers in systems of care.

- Residential care should, and can, usually be short-term (30-90 days) and focus on meeting those immediate behavioral and mental health needs that cannot be me tin the community. The longer term treatment needs of the child should, and generally can, be met in the community whenever possible.
- Residential treatment should be pre-authorized by the Purchaser, and the Purchaser should review all requests for placement extensions to ensure that placement progress is being made and to ensure quality care for the child in placement. (See Appendix I for Sample Resident Treatment Authorization Agreement).

- Care planning for treatment in the residential care center should be integrated into the larger Plan of Care already established by the Child and Family Team. The placement in the Residential Treatment Center should be one of many strategies the Community Team uses to achieve the overall family vision and Care Plan objectives.
- The Residential Treatment Center staff should join the Child and Family Team as integral members of that team in developing services both within Residential Treatment Center and afterwards to help successfully transition the child to the community. *The idea should be that the child never leaves the community even when residential care is one of the services being employed.*
- Parents, other caretakers, and siblings should be supported and encouraged to be actively involved in the residential-based treatments, i.e., family therapy, parent support groups, recreational activities, etc.
- For those youth identified as high risk or with special needs, special attention should be paid to collaborative safety planning inclusive of the members of the child and family team.
- Families should be given a choice of residential treatment facilities for their children consistent with the type of youth admitted and strengths and resources of each facility.
- The family should have a clear picture of the desired outcomes for the child while in the residential facility, i.e., what are the treatment goals, indicators for meeting those goals, specific interventions and period of time in which they are likely to be achieved?
- Every child should have a Crisis Safety Plan, and the Residential Treatment Center should be involved in the development of that plan with the Child and Family Team. The Crisis Safety Plan should assist the residential center in dealing with potential crisis situations while the child is in residence and assist the youth and family in effectively managing home visits and in preparing for a safe return of the child to the community.
- The Child and Family Team or Coordinated Community Planning Team should receive regular progress reports and clearly be updated on what short-term goals have been met, what remains to be met, and what community-based resources have been developed to help transition the child back home or to another community placement.
- Discharge should occur when the immediate identified needs have been met and sufficient community resources put in place to address longer term treatment needs.

VI. Challenges for Purchasers and Providers of Residential Treatment in "Re-engineering" Services

Implementing these best practices and the re-engineering of residential services does not happen overnight. Wraparound Milwaukee, as a purchaser, faced numerous challenges as the role of residential treatment radically shifted in the mid 1990's. Some of the same obstacles and "opportunities" are just as relevant today for other communities.
These include:

Challenge # 1 – Obtaining Political Support for the Change in Role

Child Welfare and Juvenile Justice were fundamentally tied to residential treatment programs that were long term and where the centers determined what children needed and how long they stayed. Payment for this care was segregated in each system's out-of-home institutions purchase line. There was no access in Wisconsin at that time to any Medicaid funding.

Shifting the thinking of Child Welfare and Juvenile Justice into purchasing short-term residential treatment and investing more in community-based programming required some practical demonstrations. Wraparound Milwaukee created a "25 Kid Pilot Project" aimed at returning 25 youth with no immediate direct discharge plan from the Residential Center back to the community. Seventeen youth were returned in 90 days and the success of the Pilot Project convinced Child Welfare and Juvenile Justice to develop and fund a much larger effort-that became Wraparound Milwaukee.

Challenge # 2 – Getting the Support of the Legal System

A major hurdle that needs to be taken on in many communities is the Judges, District Attorneys, Public Defenders, etc. In many committees, residential placements are directly or indirectly court-ordered. Because of the safety issues, the judiciary in Milwaukee needed to be convinced that a child could be kept just as safe in the community without residential care or with short-term care of 30-90 days. The 25 Kid Pilot Project was helpful but also being able to develop very good crisis plans in the community to keep

children and communities safe was equally important. Judges need to be at the planning table from the beginning and they need to see data that shows these youth can have good or better outcomes with more limited stays in residential care.

Challenge # 3 – Creating Pooled or Blended Funding System

Perhaps no greater challenge exists for communities, who desire, like Milwaukee to pool funding from Child Welfare, Juvenile Justice, and Medicaid. Wraparound Milwaukee was able to do it through offering both cost savings and improved outcomes. This meant that Wraparound Milwaukee had to develop the capacity to better manage youth headed for residential care, get more children home from these centers and create alternative community programming. Any Purchaser intending to do this must control the funding for residential care. Purchasers must find a way to make each system stakeholder a "winner" in this process. The child welfare system and juvenile justice department ultimately negotiated a monthly case rate with Wraparound Milwaukee which was nearly 50% less than what they were paying for residential treatment. Medicaid ultimately gave Wraparound Milwaukee a capitated monthly rate at 95% of what the actuaries said the youth cost Medicaid. Each system saved money from the start through the case rate and capitation methodology. Since Wraparound Milwaukee accepted total risk for cost overruns, those systems felt comfortable with having Wraparound Milwaukee as the MCO of the new system of care.

For Purchasers looking at the Wraparound Milwaukee model, creating a Managed Care Organization (MCO) to receive and administer the funds is imperative. Wraparound Milwaukee is a public MCO but private models exist in Madison, Wisconsin, Indianapolis, Cincinnati, and elsewhere. While Purchasers must learn a new technology, i.e., prior authorization, per client per month costs, claims adjudication claims, treatment protocols, utilization review, creating provider networks, etc., once mastered, other system stakeholders will be less apt to want to take back funding since they do not have this managed care experience and technology.

Challenge # 4 – Partnering with Residential Treatment Centers to Expand the Array of Services and Participate in a Provider Network

Critical to Purchasers desiring to work with residential treatment centers to shorten stays, reduce census and achieve more measurable outcomes is the need to help them find alternative roles to play in a continuum of care. From the initial decision of the system stakeholders to fund Wraparound Milwaukee for the purpose of reducing residential care utilization, meetings were held with all Residential Treatment Center Directors. These meetings involved Wraparound Management, the Director of Child Welfare, Chief Probation officer and the Chief Judge. Wraparound Milwaukee's approach as the Purchaser of residential care was to look at these centers, not as placements for children, but as resources for children. Residential Treatment Centers were encouraged to expand their range of community services and to be part of a Provider Network. Organized on a Fee-For-Service basis, this meant that residential centers would now offer and be paid on unit basis for:

- Short-term residential program
- Crisis and respite care (24 hours to 14 days)
- In-home treatment teams
- Mentors and Tutors
- Treatment foster care
- After school programs
- Independent living apartments
- Day treatment/alternative school

Wraparound Milwaukee has created a network of now over 250 Providers and nearly 80 different services. Nearly every residential center in existence in 1997 when Wraparound Milwaukee embarked as the MCO is still in existence today. The overall number of residential beds is significantly less, but most residential providers have developed other of community services and resources to fill their budget gap.

Challenge # 5 –Providing Training and Technical Assistance to Residential Centers

Purchasers need to be prepared to provide training and technical assistance to Residential Care Providers. The "best practice" approaches described were the result of working very closely with the residential treatment center's clinical staff and offering them technical assistance on understanding and applying wraparound approaches, engaging families in treatment programs, working as a member of a child and family team to develop a care plan versus directing all treatment themselves, strength-based care and transitioning children more quickly. Purchasers should think about cross training care managers who oversee the delivery of residential care and who organize the child and family team process and the residential facility's clinical staff.

Challenge # 6 – Establishing Outcomes for Residential Treatment

Purchasers need to clearly establish measurable and observable goals to be attained by a youth within residential based treatment. This will often relate to the specific behaviors that resulted in the need for residential care but may not include all the treatment needs of the youth.

The latter may be met through interventions provided in the child's home and community. For example, attending a school program is important but staying in the residential treatment center for several additional months or more just to finish an on-grounds school semester may not be a good justification to keep a child in such a restrictive placement.

Purchaser's need to be able to closely monitor the goals, ensure they are individualized for that child and that progress reports are received at least every other week as to the child accomplishing the most immediate goals to enable the child to return to the community for longer term care.

VII. Challenge for Residential Treatment Provider in "Re-Engineering" Services

In implementing a "re-engineering" plan similar to Wraparound Milwaukee, the Providers of Residential Treatment are presented with a range of challenges and opportunities.

Challenge #1 – Reframing How Decisions Are Made

Residential Treatment Directors have said that one of the most challenging issues have been, and continue to be, the change in decision making. Residential centers were use to making all treatment decisions, including what services a child received or how long they stayed. With evolution of the Wraparound philosophy, care was coordinated by care coordinators working for the Purchaser and treatment decisions made by the child and family teams. These teams had the active involvement of families; of natural supports, i.e., relatives, friends, neighbors, church members; of outside professionals, i.e., mentor, in-home therapist, etc., of community teachers and counselors. Care Coordinators and child and family teams were looking not for structure and control, but for individualized, tailored care plans. The fact that the on-going treatment team in the residential center continues to be the child and family team was a very different concept for the residential centers to accept.

Over time the residential centers clinical staff began to see that the youth were doing better in the community and more families were staying together. There was more support for the child to be successful.

Challenge #2 – Moving to Strength-Based Model

Residential Treatment Center Directors have told me that the philosophical differences in strength-based approaches versus more consequence oriented approaches were far more difficult than anticipated. Residential Centers were very structured and more punitive in establishing negative consequences for non-conformity. Wraparound philosophy is more strength-based. Children need to manage their own behaviors versus the facility

managing the behavior. Residential centers felt that Wraparound as Purchaser was taking away their tools of resident control.

Residential centers, however, developed internal committees/work groups to replace the existing level systems with a system of more rewards and problem solving skills that could be taught to residents.

Challenge #3 – Having Our Work Evaluated

The Residential Centers in our system were not use to having their work evaluated. The extensive use of such managed care instruments like utilization review, chart audits, performance reviews, and prior authorization of all residential treatment at 30-90 days intervals was very new and not initially appreciated. But in time, it was seen as a way of continuing to emphasize quality and cost-effective care.

Challenge #4 – The Reduction in the Number of Residential Beds

In the pre-Wraparound days, there were plenty of children for the available beds—youth were shared among the Centers and placed, as slots opened. There is now a much more competitive situation taking place as the number of empty beds has grown. Purchasers look to buy those residential programs that are more short-term, that demonstrate a willingness to partner with families, and that offer an array of services and a better continuum of services.

Residential centers had to diversify their service array to survive and really gear their services and resources to what the consumer wanted and needed.

Challenge #5 – Treating Children in Their Natural Environments

As length of stays decreased, Residential Treatment Centers were challenged to be more active in successfully transitioning the child back in the community. This meant residential staff going into the community during the day and evenings to work with families on some of the parenting skills and remaining treatment issues. This amount of community work was very different and immediately presented some concerns about

staff safety. Several residential centers paired staff on in-home teams of therapists and child care workers to effectively and safely work in homes.

Challenge #6 – Workforce Issues

A challenge for Residential Treatment Centers was the changing roles staff had to take on. The child care staff were use to much prescribed roles within the center. With the evolution of Wraparound Milwaukee, staff had to become generalists. They took on multiple roles working within the Center and going into the community to provide services. They were supported in taking on these roles, through extensive re-training conducted by the Centers and Wraparound Milwaukee.

Challenge #7 – Expanding Funding Sources for Residential Treatment Programs

As residential centers broadened their service array, they were challenged to find more funding sources. This meant building funding support beyond just Wraparound Milwaukee but looking at Medicaid to fund day treatment and in-home therapy from other Purchasers like Child Welfare, Special Education and Juvenile Justice. New programming funded under TANF, W-2 reinvestment funds, commercial insurance, and HMO's needed to be developed. Residential Centers have to become very resourceful at identifying new funding sources.

Adjusting to providing services on a fee-for-service basis with no guaranteed contracts or volume of business was also very challenging. Residential Centers had to react to changing demands very quickly which meant re-deploying existing staff and hiring more staff on a contractual basis.

VIII. How One Residential Treatment Center Embraced a Wraparound Philosophy to Re-Engineer Its' Organization - St. Charles Youth and Family Services, Inc.

In the "good old day" residential agencies in Milwaukee rarely had to consider seriously, their financial health or the changing demands of the market. With length of stays of one, two, or more years, every bed was full and the budget balanced. Even as Wraparound

Milwaukee was initiating early system changes, there was already a realization among some residential CEO's in Milwaukee that residential care was not resolving the increasingly complex situations children were facing-children and families needed to be treated in their own environment.

As an agency originally founded as a boy's home in the early 1900's, St. Charles had seen itself as a Residential Treatment Center for most if its' history. It had only begun to put a small fraction of its budget into the delivery of some in-home services in the late 1980's and early 1990's.

With the evolution of Wraparound Milwaukee and its strong emphasis on treating children in the context of their family and community and the de-emphasis being placed on utilization of residential treatment, St. Charles and other residential agencies faced some very fundamental questions:

- Were they going to be facilities-driven service providers, or free themselves to serve youth and families wherever they might be?
- Were they going to embrace the trend that demonstrated movement away from long-term residential based services and transform themselves to meet the changing market trends?
- Who would St. Charles be if it no longer defined itself by its residential facilities, in which it had invested so heavily over many decades?
- What would St. Charles or other centers do with all those facilities if the days of multi-year residential stays were ending?

St. Charles Boy's Home took the opportunity presented by Wraparound Milwaukee to transform the agency into a comprehensive youth and family-oriented provider capable of serving families holistically in their homes and communities. The change was more fundamental than simply a name change.

St. Charles sought out, bid for, and received one of the first care coordination contracts with Wraparound Milwaukee. Care Coordinators or Case Managers were integral to

facilitating the Wraparound process and coordinating care in the child and family's home and community. Eventually, St. Charles also added a new type of family preservation care manager, called safety service managers, to work with at risk child welfare families, as well as a specialized new case facilitator to work with mothers with serious substance abuse problems. A total of 20 care management staff were hired in the three areas.

Since Wraparound Milwaukee had developed a Fee-For-Service Provider Network to provide an array of mental health, social and support services for these three program areas, St. Charles paid close attention to the needs children and families were identifying and how those needs translated to needed services in the community. To meet some of the educational needs not being met in the school, St. Charles used its residential facilities to develop new alternative education and day treatment programming and an in-home tutoring program. The mental health in-home services and counseling component was expanded as families' utilization of in-home over office-based therapy increased. St. Charles understood that children with serious emotional needs often came from single-parent homes and the need for role models and adults to help a youth structure his/her time could be met through a core of community mentors. St. Charles developed a mentoring program on a fee-for-service basis and developed a part-time core of over 100 mentors. Some residential staff eventually assumed roles in these various programs.

St. Charles revamped its residential services to accommodate the shorter stays under Wraparound Milwaukee's approach. Programming in the center was geared to reintegrating children back into their home or community within 30 days. St. Charles also developed a treatment foster care component to be an alternative to residential care or to facilitate the transition from the residential center to the community.

As St. Charles transformed it's programming, it also needed to transform its campus facilities to bring them in line with the change in utilization of residential treatment beds. Some facilities were renovated to house new initiatives such as the alternative school and day treatment program. Excess space on the campus was leased out to other organizations, and unimproved land no longer needed, was sold for commercial

development. Even as it reassigned the use of space at the 7.5 acre campus, the agency did acquire office space in the community, itself, to house office for case managers and some of its mental health and counseling services.

St. Charles and its Board recognized both the urgency and absolute necessity for change and united internally to "re-engineer" its programming. Today, it offers over $12 million of services across more than 25 distinct programs in partnership with Wraparound Milwaukee, Milwaukee County, and the State of Wisconsin.

In summary, it is obvious to these writers that Residential Treatment Services can and should re-conceptualize their role, mission and goals as well as their service delivery systems. The "re-engineering" of residential programs that have been largely unchanged for many years is initially different and sometimes painful. However, the rewards from focusing services and programming on what children with complex needs and their families need most to function as a unit within their own home and community comes and achieving better outcomes for them is the greatest reward. In Wraparound Milwaukee, this has been better clinical functioning on such nationally normed instruments as the Child Behavioral Checklist (CBCL) and Child and Adolescent Functional Assessment Scales (CAFAS); improved school attendance and performance; reduction in juvenile justice recidivism rates; and significantly higher family satisfaction.

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Date Entered:_____
By whom:_____

WRAPAROUND MILWAUKEE
RCC PLACEMENT AUTHORIZATION/AGREEMENT

To be completed by Wraparound Milwaukee Management

Date Rec'd by Liaison_____Liaison receiving request_____

☐ Approved ☐ Denied Date Authorization Expires_____

Reason for Denial/Recommendations_____

_____

By whom/Signature_____Date_____

If Approved, Agency receiving placement_____
Director or Unit Manager Signature_____Date_____

☐ Initial Review ☐ Youth on High Risk List ☐ Renewal

Date submitted_____Child's Name_____
Date of current RCC placement_____Length of time requested_____
Social Security #_____D.O.B._____Court #_____
Start date of Wraparound Enrollment_____
Care Coordinator_____Telephone_____
Care Coordinator Agency_____Supervisor_____
Date of most recent Plan of Care_____Judge_____D.A._____
Child's Attorney_____P.O./BMCW Worker_____
☐ Delinquency Exp. Date_____ ☐ CHIPS Exp. Date_____ ☐ JIPS Exp. Date_____
Current School_____Special ED? ☐ Y ☐ N (Circle one: ED LD OHI CD)

PLEASE NOTE: IF YOUTH IS PLACED WITHIN AN RCC PLANS MUST BE MADE IMMEDIATELY TO ARRANGE FOR HIS/HER RETURN TO A COMMUNITY BASED SCHOOL.

Child and Family Team Members _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Is there AGREEMENT within the entire **Child and Family Team** regarding the identified child's treatment needs? ☐ Yes ☐ No.

If no, explain_____
_____

Identified **Relevant Strengths and Resources** of Child, Family and Community Team:
_____
_____
_____

Please list the **Youth's Needs**, which are expected to be met by RCC based treatment:

Why does the team believe that a RCC is necessary, at present, to meet the above needs?

What **community-based alternative** resources/strategies have been considered/attempted by the Team in order to meet the above NEEDS? (Please be specific):

Is there a resource that, **if it were available**, would allow the youth to successfully remain at/or return to home? (Or in a less restrictive environment): ☐ Yes ☐ No
If yes, what is it?

Where/with whom is the youth expected to live following RCC-based treatment? (Please list names and address of caretaker):

If this placement plan is not achieved at discharge, what other appropriate placement is available for this youth?

What school will he/she be attending following discharge from the RCC?
Who is the contact person at the above school Phone

☐ **If this is an Initial Review-**

What are the **SPECIFIC SHORT TERM GOALS (observable and measurable)** to be attained by the youth within RCC based treatment? (Please list the expected completion date for each goal):

What needs to be different in order for the **Child and Family Team** to feel comfortable with the Youth living at home (or in a less restrictive environment)?

Has a **SAFETY/CRISIS PLAN** been developed to assist the youth and family (or caretaker) in effectively managing home visits and in preparing for a comfortable/safe return to home? ☐ Yes ☐ No

If not, by what date will a SAFETY PLAN be completed:

Is the identified youth currently involved in individual or group psychotherapy?
☐ Yes ☐ No Provider_____

Has there been a psychiatric or psychological evaluation of the youth within the last year?
☐ Yes ☐ No Psychiatrist or Psychologist_____

Is youth currently prescribe any psychotropic medications? ☐ Yes ☐ No
If yes, what medication(s)

_____Prescribing M.D._____
_____Prescribing M.D._____
_____Prescribing M.D._____
_____Prescribing M.D._____

Is the family currently involved in family therapy? ☐ Yes ☐ No Provider_____

Please list other community-based services being provided to the child and family (formal and informal):

_____
_____
_____
_____

☐ **If this is a Renewal** – What specific short-term goals been have **met**? (Refer to prior RCC request and list achievement dates). What **specific, measurable goal remains?** (List expected achievement dates):

_____
_____
_____
_____
_____
_____

☐ **If this is a Renewal** – What community/neighborhood-based resources have been identified, developed, coordinated, or made available to the family within the last authorization period to assist in successful family reunification:_____
_____
_____

☐ **If this is a Renewal** – What are the barriers to discharge? **How are they being addressed, and by WHOM?**_____
_____
_____

Parent/Guardian Agreement and Consent to RCC based treatment for Youth

(PARENT/LEGAL GUARDIAN must initial each item)

- I have been informed of alternatives to RCC-based treatment for my son/daughter. Yes_____ No_____

- I have discussed with my Wraparound Child and Family Team Members the potential benefits and risks of RCC-based treatment and its alternatives and my questions have been answered. Yes_____ No_____
- I agree to actively participate in all family treatment, visits, Child and Family Team Meetings, and Parent Meetings which I will help schedule as part of my son's/daughter's treatment. Yes_____ No_____
- I understand that my Wraparound Care Coordinator is responsible for assisting me, as necessary, with transportation to and from such meetings if this becomes a need during my child's RCC-based treatment. Yes_____ No_____
- I agree to actively participate in SAFETY PLANNING, as appropriate, and to provide appropriate supervision, **to insure the safety of all** during home visits and in preparation for my child's return to live at home, or in a less restrictive environment. Yes_____ No_____
- I agree to work closely with my Wraparound Care Coordinator and other Team Members to insure that my child receives quality care and that treatment remains focused upon the needs our Team has identified. Yes_____ No_____
- I understand that I am to receive a copy of this document from my Wraparound Care Coordinator and that I am to be actively involved in any decisions made regarding the treatment of my son/daughter. Yes_____ No_____

SIGNATURE	DATE	PHONE NUMBER	AGREE WITH ABOVE PLAN (YES OR NO)
_____	_____	_____	_____
Family Member			
_____	_____	_____	_____
Family Member			
_____	_____	_____	_____
Child			
_____	_____	_____	_____
Care Coordinator			
_____	_____	_____	_____
Therapist			
_____	_____	_____	_____
Care Coordinator Supervisor			
_____	_____	_____	_____
Team Member & Role			
_____	_____	_____	_____
Team Member & Role			
_____	_____	_____	_____
Other			

JLB/RCC Placement Form
Revised 6/5/02 – DDP

PROGRESS REPORT

Date: _____

Youth's Name: _____ **Date of Birth**: _____

Name of Facility: _____

Date Youth was Placed: _____

1. **What was the presenting need which led to this placement**?

_____

_____

2. **Strengths demonstrated to date relevant to resolving the presenting need**?

_____

_____

3. **List services provided to date**:

	Date Initiated	**No. of Sessions**	**Provider**
Individual Treatment Sessions	_____	_____	_____
Group Treatment Sessions	_____	_____	_____
Family Sessions	_____	_____	_____
Other _____	_____	_____	_____

4. **What needs to be different for this youth to return home or to a less restrictive setting**?

_____

_____

5. **What have you discovered works best with this youth to promote his/her progress**?

_____

_____

6. **Describe the youth's family involvement and what you have done to enhance their involvement**?

_____

_____

7. **What has been done to transition services/supports to this youth's home and community**?

_____

_____

8. **Any other pertinent information regarding the request for continuation of placement**?

_____

_____

Name of Person Completing Form _____

DDF – 1/1/01 – RCCCY Progress Report